JOURNAL OF THE ROYAL COLLEGE OF NURSING

NURSING TIMES

Macmillan and Company Limited London — Friday, March 30, 1956

EDITOR: MISS M. L. WENGER, S.R.N., S.C.M., DIPLOMA IN NURSING, UNIVERSITY OF LONDON

Printing Dispute Settlement

OUR READERS AND ADVERTISERS will share our relief that the provisional settlement of the printing dispute meant the return to work this week of over 16,000 printing staff. Owing to the Easter holiday we are still only able to publish a small issue but hope to regain normal publication as soon as possible. We have appreciated warmly the sympathetic comments of a number of our readers.

WHO International Conference on Nursing Education, Scotland

THE INTERNATIONAL CONFERENCE on Nursing Education, arranged by the Regional Office for Europe of the World Health Organization, is to be held at Peebles Hydropathic Hotel from June 13-26, 1956. The subject of the conference is Post-basic Nursing Education, and various expert consultants from Canada, France, Germany and the United Kingdom will deal with the problems involved in the planning and organization of courses of instruction for nurses who have already completed their basic training.

Two delegates from each of eighteen European countries are expected to attend the conference. The six delegates from Great Britain and Northern Ireland are Miss A. M. Downton, matron, University College Hospital, London; Miss H. M. Hogg, health visitor tutor to the County Borough Council of Nottingham; Miss M. C. N. Lamb, education officer, Royal College of Nursing, Scotland; Miss E. G. Manners, matron, Royal Infirmary, Glasgow; Miss J. B. Price, director, School of Nursing for the United Sheffield Hospitals; Miss A. M. White, nursing officer, Northern Ireland Hospitals Authority, Belfast. Dame Elizabeth Cockayne, chief nursing officer, Ministry of Health, London, and Miss M. O. Robinson, chief nursing officer, Department of Health for Scotland, have also been invited to attend.

The local arrangements are being made by the Department of Health for Scotland and representatives of the nursing profession in Scotland, with Miss Alves Diniz, regional nursing officer for Europe of the World Health Organization.

Nurses' Salaries

A MEETING of the Nurses and Midwives Whitley Council on March 20 considered the recent claim for a general increase in salaries of all nursing and midwifery staff within the purview of the Council. After a full discussion it was decided to continue the negotiations on Tuesday, March 27.

Right: *the DUCHESS OF KENT presenting a certificate to Miss M. C. Schurr at the presentation of Hospital Saving Association scholarships at Central Hall, Westminster. On the left is Sir Walter Monckton. Miss Schurr is taking a course at the Royal College of Nursing.*

Below: *WESTMINSTER HOSPITAL nurses with the Marion Agnes Gullan Trophy; left, Miss M. J. Smyth, right, Miss L. Young, matron, and behind Miss Gibbon, principal tutor. Full report Stop Press Supplement.*

Contents

	PAGE
TOPICAL NOTES	235
ALLERGY AND THE ECZEMAS	236
TRAINING PSYCHIATRIC NURSES—A CHANGE OF EMPHASIS	240
BOOK REVIEWS	241
STOP PRESS (SUPPLEMENT)	
A POST-OPERATIVE OBSERVATION WARD ...	243
FOUR MONTHS IN A DISTRICT HOSPITAL ...	244
NURSING SCHOOL NEWS	245

ALLERGY AND THE ECZEMAS

by D. E. Oakley, B.CHIR., M.R.C.S., L.R.C.P., Consultant Dermatologist, The Royal Hospital, Wolverhampton.

THERE is perhaps no scientific word that has been so freely adopted by the lay public as the word 'allergy'. Curiously enough it is for the most part used fairly correctly, but not, I think, with full cognisance of its true significance.

If we are to understand this very important subject, the eczemas, we must be fully conversant with the allergic phenomenon in all its implications and I shall therefore make no apology for devoting considerable space to the elucidation of the term allergy in relation to similar phenomena.

There are three such phenomena which should concern us—anaphylaxis, allergy and atopy, and I propose to give a brief résumé of each and their relationships to each other.

For many years it has been recognized that bacterial activity in any organ in the body may lead to changes in other organs at a distance from the original focus of infection. Good examples are scarlet fever, where the infection is localized in the upper respiratory tract and the classical eruption is produced remotely, and infection with the Corynebacterium diphtheriae in which the distant effects are seen perhaps in the myocardium and nervous systems.

There are two ways in which this remote effect may be brought about:

(1) Simply, by dissemination of bacteria from the focus of infection *via* the bloodstream to the distant tissue. Such a state of affairs is seen in disseminated lupus vulgaris.

(2) In more complicated fashion by the absorption of toxins into the general circulation.

As the skin is an active organ it is liable to suffer, in common with other organs, from toxins absorbed or bacteria disseminated from any focus of infection elsewhere in the body. When such a focus is acute, as in scarlet fever, the relationship between the focal infection and the skin eruption is comparatively easily recognized, but in low grade or chronic infections the relationship may be much more difficult to establish. In this field much pioneer work has been done by H. Barber and Leslie Roberts, who suggested that any nook or cranny from the teeth to the anus may act as a lodgement for invading organisms, the product of whose toxopoietic activity may be reflected elsewhere, and particularly in the skin, as certain chronic dermatoses.

Here I would emphasize that the focal infection need not be very active or dramatic in order to produce remote effects. A chronic tonsillar or dental infection without frank sore throat or toothache may be responsible for toxins passing to the skin and there cause lesions by damage to the blood vessel walls, hair roots, etc. Similarly with bowel infections there may be no symptoms whatever referable to the gastro-intestinal tract but, as Danysz has pointed out, remote effects upon the skin may be considerable.

In dealing with this concept of toxic absorption we are dealing with a problem of no small complexity, some aspects of which are not yet altogether explained. It would seem, however, that toxins elaborated focally are absorbed as undigested foreign proteins, antigens in fact, which by repeated introduction into the bloodstream in small quantities or spasmodically in larger doses lead to cell damage or even destruction elsewhere, and among other places in the skin.

It thus becomes clear that focal infection is intimately linked with the process known as sensitization.

May I digress to draw a clear distinction between sensitization and sensitivity?. Sensitivity is an inherent and individual over-sensitiveness to a given substance, whereas sensitization is a specifically acquired hyper-reactivity to an antigen, developed through contact with that antigen over a period of time and is a state that may be produced to a variable extent in most, if not all people. This has been admirably shown by Bloch who sensitized himself to the primula obconica.

Anaphylaxis

Let us now turn to the problem of anaphylaxis. This is the name given in the first place by Richet to an intense and often fatal effect produced in animals by the injection of a proteinoid substance but which would not adversely affect a normal animal at first injection. Anaphylaxis usually follows the injection of a completely harmless substance allowing for an incubation period of some 10 days after the original sensitizing injection. Such a state of sensitization may last for weeks, years or throughout life, and is absolutely specific for the substance injected; for instance a person may be sensitized to horse serum and not to cow serum.

Passive anaphylaxis is recognized where the injection of the serum of an anaphylactized animal into a normal animal may produce in the latter a state of anaphylaxis, though usually a large number of injections are necessary. It is important to realize that the anaphylactic state is always acquired, never inherited, and moreover desensitization is not usually a difficult matter.

Richet in his book referred to certain reactions occurring without a previous sensitizing injection, for example, the symptoms of serum sickness, erythema, pruritus, urticaria, fever and malaise which occur after several anti-diphtheric injections given within a space of 10 days, and even after one injection of horse serum. These he regarded as anaphylactic, but von Pirquet and Schick in 1906 coined the term 'allergy' for this phenomenon and described it as an "altered reactivity to various foreign proteins or physical agents which are harmless to the majority of people." These substances may be exogenous or endogenous and may enter the body *per vias naturales* as distinct from the parenteral route.

The biochemistry of anaphylaxis is presumed to be somewhat as follows. The injected antigen causes the production of antibodies which act as precipitins. While these antibodies remain in the blood they produce immunity by precipitating and thereby rendering innocuous further doses of antigen. But after a time they largely disappear from the blood and enter the tissues. If antigen is then injected into the patient the antigen is not neutralized in the blood but enters the tissues. Here it unites with

Abstract of an address given at a study course arranged by the Birmingham Group Occupational Health Section, Royal College of Nursing.

the antibodies, there is a sudden break-down of protein molecules and the production of toxic amino-acids, very like histamine, and these amino-acids produce the symptoms of anaphylactic shock.

Allergy

Allergy, though clearly related to anaphylaxis, has certain significant differences. It has been defined as " a state of altered reactivity of a tissue as a result of previous contact with an allergen or antigen." Here again let us be quite definite as to what we mean by ' allergen ' and ' antigen '.

An antigen is, of necessity, a protein substance, but other non-protein substances, such as nickel which of themselves cannot produce antibodies, can cause allergic reactions. In such circumstances the substance combines with proteins to form haptens which act as antigens. Such non-protein substances are known as allergens.

As cold can best be defined as the absence of heat, so allergy can be defined in its relation to anaphylaxis. *In the first place* there is a definite allergic diathesis. In a large proportion of cases a family history of allergic tendencies may be obtained. These may be traced through either the maternal or paternal side of the family tree, tend to be multiple in nature, differing from those of the parent, and of long duration.

Rackermann 1931 gives the following figures.

Out of 208 cases of infantile eczema, 36 per cent. gave a family history of allergy.

Out of 63 cases of adult eczema, 50 per cent. gave such a history.

Out of 75 cases of urticaria, 25 per cent. were familial.

Secondly, anaphylaxis can be readily obtained in the majority of animals and in man, but the average person does not readily develop allergic reactions. Here it may be appropriate to mention the problem of latent allergy. In some trades workers may show marked reactions to intracutaneous injections of antigens with which they come into intimate contact, and yet remain entirely free from cutaneous manifestations.

Thirdly, anaphylactic reactions are constant and predictable whereas allergic reactions are usually multiple, such as the asthma prurigo syndrome, and the case of the person who suffers from eczema in infancy, hay fever in adolescence and urticaria or asthma in later life.

Fourthly, anaphylactic reactions are always short-lived, the subject either dying quickly or else as quickly recovering. Allergic reactions or their sequelae on the other hand are of much longer duration.

Fifthly, there is frequently a nervous element in allergy which plays a considerable part in precipitating allergic crises, a factor of major importance in some dermatoses.

Sixthly, anaphylaxis is transferable passively from one animal to another whereas the transference of allergy can be accomplished to a limited degree only.

Prausnitz and Küstner in 1921 showed that small areas of skin could be sensitized by intradermal injection of serum from an allergic subject. Some time previously (1911), Küstner, who was allergic to fish, had in this way sensitized Prausnitz, and the sensitization lasted four weeks. Similarly, a person can be sensitized to cold by inoculation of the serum of another person who reacts to cold by the production of urticarial wheals. This is caused by the presence in the serum of the originally sensitive person of a substance known as dermolysin.

Lastly in anaphylaxis there is always the clear history of a sensitizing injection, whereas a history of a sensitizing contact is not always easy to obtain in the case of allergy.

Those are the main differences between anaphylaxis and allergy.

GAY SEALS HELP THE DEAF CHILDREN'S SOCIETY—

—and decorate your gifts with the attractive flower seals obtainable from the Society at 1, Macklin Street, Drury Lane, W.C.2, price 6d. for six.

It is possible that anaphylaxis is associated with the formation of peptone in the tissues, especially in view of the shock response provoked in dogs by the injection of peptone, while allergy is associated with the formation of what is known as H-substance, a substance closely allied to the amino-acid histamine. H-substance may be normally present in the tissue cells and be liberated as a result of the allergic reaction.

If a drop of histamine is put on the skin there is a prompt local dilatation of the blood vessels followed by an extravasation of serum. Histidine, the precursor of histamine, is found in all tissues and from it histamine may be split off by a simple process of oxidation. Moreover Harris has shown that there is a substance similar to histamine extractable from human skin and present there in a concentration six times greater than in the underlying tissues.

If the skin is stroked lightly a white line appears, due to constriction of the superficial vessels. If stroked more firmly a red streak appears, due to dilatation of these vessels. If the skin, thus stimulated, is further observed, especially in susceptible subjects, a widespread dilatation of arterioles appears followed by a wheal due to the extravasation of serum. The resemblance to the histamine response is obvious and is due to the release of H-substance from the epidermal cells. The reaction can be provoked by stimuli of many kinds, mechanical, thermal, electrical and chemical.

It is seen, therefore, that histamine is the substance which can, *par excellence*, theoretically produce allergic phenomena and in the skin we have a large potential source of histamine-like substance.

McKenna says: " Given the hereditary background, perhaps some endocrine dysfunction, oral sepsis, constipation or dyspepsia, it will be seen that a person can readily develop cutaneous allergic manifestations. Perhaps even such qualifications are not necessary. It is said that every person who handles constantly salts of nickel develops nickel dermatitis, and Bloch has shown that whereas normally only a few persons are sensitive to primula obconica, every person can be sensitized to that plant by using a concentrated extract thereof ".

Sensitization of the skin to exogenous antigens and allergens depends therefore upon the frequency and duration of exposure and the concentration and type of the agent employed.

It must, however, be fully appreciated that the allergic cutaneous reaction depends upon which part of the skin is sensitized. If the reaction is confined to the epidermis it is the cells of the Malpighian layers which are sensitized and the type of response is known as eczema. This does not, of course, mean that all eczemas are allergic in origin, but simply that the epidermal reaction to an antigen causes signs and symptoms which we call eczema; these signs and symptoms are redness, due to a nervous reflex from the stimulated epidermis to the superficial capillaries,

accompanied by a variable amount of itching and burning. This is followed by 'spongiosis', by which is meant oedema or accumulation of fluid in and between the cells of the epidermis, leading to the formation of vesicles or small blisters. These vesicles burst and produce the fully established weeping stage of eczema. The flow of serum gradually diminishes, crusts form and beneath them healing takes place. As a result of scratching and rubbing there may be interference with the perfect formation of the horny layer and even secondary infection which again may be followed by a period of dryness and scaling.

In urticaria the epidermis is not usually affected and it is the corium or deeper layer that forms the shock tissue, particularly the walls of the blood vessels, whereas in angio-neurotic oedema both the corium and the subcutis are involved.

The skin may be sensitized by exogenous or endogenous antigens. If the circumstances seem to point to sensitization by some deleterious substance, " dust, liquid or vapour " with which the patient has been in contact, a patch test may be performed on some unaffected area of the skin. This is done by applying the substance either neat or in suitable dilution directly on to the skin. A negative result may be misleading, but a positive result indicated by erythema, papulation, and possibly vesiculation can usually be interpreted to mean that one at least of the antigens to which the patient is sensitized has been found.

It has been shown by Arthus and others that sensitization to a protein may be caused by absorption from the bowel of proteins incompletely hydrolized owing to some digestive abnormality. The patient becomes sensitized by these proteins and his skin becomes allergic to them. As a result of this observation a series of skin tests has been devised with a view to discovering the particular protein, either food or bacteria, to which the patient has become sensitized, a positive or urticarial reaction at the site of cutaneous injection indicating a state of sensitization to the substance used. It would seem natural to suppose that these tests should give valuable and accurate information as to the specific cause of a given reaction, but unhappily this is not so. While they should undoubtedly be employed in all cases of doubtful origin, only too often it is found that the reactions are so indefinite, uncertain and sometimes complicated, that instead of clearing the situation they cloud it further.

Atopy

There is one further concept to be considered, that of atopy. This word is derived from the Greek, meaning 'strangeness', and was coined by Coca in 1926 to define certain clinical forms of human hypersensitiveness that do not occur, so far as is known, in lower animals and which have a hereditary incidence.

The substance to which the patients are sensitive are known as atopens and the antibody-like substances found in the blood are called reagins. It has been suggested that atopens may be absorbed through the skin and other surface membranes, such as the mucous membranes.

The diagnosis of an atopic eruption depends upon the fulfilment of the following criteria:

(1) There must be a family history of asthma, eczema or hay fever.

(2) There must be a personal history of similar conditions. It must be possible to demonstrate the Prausnitz-Küstner phenomenon of passive transfer of sensitization.

When dealing with infants it is not always possible for all these postulates to be fulfilled, but since a large proportion of the cases present as eczema (90 per cent.), and as an accurate family history is usually obtainable, the diagnosis of atopic eczema can frequently be made with considerable accuracy.

It should be remembered that all cases of infantile eczema are not atopic, since the hereditary factor which is essential for a diagnosis of atopy is not always present, and in fact Stokes has expressed the opinion that the majority of cases of infantile eczema are allergic rather than atopic.

The atopic child may not be fat and well nourished, as is usually the case with allergic subjects, the eruption frequently begins on the face and extends to the limbs, more particularly the flexures. Itching and restlessness are prominent features, but in spite of this the infants appear to thrive and it is the parents who look more exhausted and appear more disturbed than their offspring.

Most cases of infantile eczema improve between one and two years of age but in some, the true atopic cases, a leathery thickening of the skin appears on the bends of the elbows and knees and the sides of the neck, and sufferers are liable to bouts of excessive itching, accompanied by oozing and an outbreak of eczematous lesions on the face and elsewhere.

Asthma and hay fever may develop in these patients but it is a curious fact that while these features of atopy are in the ascendant, the skin lesions frequently, but only temporarily, retrogress.

Stokes has aptly put it thus: " The allergic skin, like the average nervous system, may go through prostration once or even twice and recover on removal of an excitant and the correction of one or two predisposing causes. The skin of the atopic individual is in such a state of constant protesting hyper-irritability that no sooner is it relieved of one set of contacts and excitants than it seizes upon another group and explodes or prostrates with renewed vigour."

The Individual

This, then, is the background of the eczemas. I have already said that all cases of eczema are not allergic. It is possible and indeed quite common for the skin to respond to the stimulus of simple irritation with the eczematous reaction, that is spongiosis, and thereby produce the eczematous picture, indistinguishable from that produced by the allergic antigen antibody reaction. We have seen that this is what would be expected if we accept the theoretical role of histamine and H-substance in the causation of eczema. How then are we to tackle the problem of the man in the surgery? How are we to correlate the picture which he presents with the phenomena which we have been considering?

Whether we are primarily concerned with industrial dermatitis or with the wider scope provided by the clinic in a general hospital outpatient department, the problem is the same. Why has this patient developed eczema?

Let me emphasize once more that the character of the eruption can do no more than establish the diagnosis of eczema, and need not in any way indicate its probable causation. It is, however, essential to establish the diagnosis and I make no apology for this seeming platitude. I have seen in recent weeks a man who has been drawing compensation for over 18 months for a condition which, on examination, proved to be typical lichen planus. There seems to be altogether too great a tendency for a skin rash and a hazardous occupation to be lightheartedly linked together without due consideration having been given to the criteria postulated in my earlier passages.

Let us assume that the eruption in question does correspond to the formula laid down. Before allowing ourselves to be prejudiced one way or another by the history of possible noxious contacts we must assess the

whole man with whom we have to deal. First of all his family background. Is there any history of allergy in his near relatives? Has he shown any manifestations of atopy in the past or are they present even now—hay fever, bouts of asthma, allergic rhinitis or migraine headaches? Much may depend upon a clear realization of the type of individual with whom we have to deal.

With the diagnosis made and the question of allergic diathesis clearly answered we may turn to the problem of causation, and here we are immediately faced with a whole series of bewildering possibilities. You have only to turn to the list of possible sensitizing agents published in their book by Schwartz, Tulipan and Peck to realize that there are few substances indeed that cannot, in given circumstances, produce sensitization. A clear history of contact with such a substance is an obvious pre-requisite but it must not be forgotten that such a contact need not necessarily have taken place at work, as for instance the capstan lathe operator whose hobby was the propagation of primulas, in which the offending agent proved to be the primula obconica and not the slurry oil. Furthermore there are certain practices not officially condoned such as cleansing the hands after work with suds oil or crude paraffin which hardly qualify a man for compensation on the grounds of industrial dermatitis.

To arrive at a fair conclusion we must determine the frequency, duration and degree of exposure and the concentration of the suspected agent to which a man may be exposed, for upon these factors depends his likelihood to become sensitized.

Protection in Factories

In most factories where the workers are in daily contact with known sensitizing substances various forms of protection are provided and it is our duty to assess the efficiency and availability of these methods of protection. In one factory I know it used to be the rule that new protective gloves were not to be issued until the old ones were actually perforated. The inference is obvious.

In yet another factory the best of intentions defeated their own objective. The process entailed considerable contamination of the hands by grease. A powerful detergent was supplied with which to cleanse the hands at the mid-day break, and it was apparently extremely effective, indeed too effective because it removed not only the extraneous grease but all the natural protective fat on the skin surface and left the hands fatally exposed to the grease contacted in the afternoon session.

For Nurses

This, of course, raises the whole question of the cleansing of the skin after contact with oil, grease, etc. I would utter a word of warning to you as nurses. In the course of your professional duties you may be called upon to handle some of the most potent sensitizing agents that we know, for instance sulphonamides, penicillin and streptomycin, and remember that your patient is as liable to become sensitized as you are yourselves. By the nature of your work your exposure to these substances is likely to be intimate, prolonged and frequent. I have seen many such cases among nurses with the most unhappy results, long periods off work or even the inability to continue training or the practice of nursing. I do beg of you to develop the simple habit of rinsing your hands in running water for a few moments immediately after handling these drugs, whether you think you have been contaminated or not.

The picture is not, however, one of unrelieved gloom. For a long time it has been known that when the allergic reaction is not too severe in the first place, gradual diminution and ultimate loss of sensitization has taken place in subjects who have remained at work. This is known as 'hardening'. Long periods off work seem to lessen the likelihood of this process which must be regarded as a process of natural desensitization due to repeated contact. In the nature of things it would seem likely that a sensitized person would take extra precautions, thereby reducing contact to a minimum, and these minimal contacts over a prolonged period produce desensitization. It is not, therefore, always advisable to insist upon a change of occupation when dealing with a sensitization eruption. Acting upon the principle implied in this process, considerable progress has been made in deliberate active desensitization of subjects to agents which have produced the sensitization. There is, I think, a considerable future for this method of combating the wiles of allergy.

'Allergy Minded'

In America there has grown up a very close liaison between the dermatologists and the industrial magnates, with the result that the average American worker is much more 'allergy minded' than ours are, and the advice of dermatologists is sought, over a wide industrial field, including such aspects as the disposal of manpower. For instance, it is recognized as undesirable to employ a man with seborrhoeic or naturally greasy skin in a process which entails exposure to fat soluble sensitizing agents, or alternatively a man with a dry skin in contact with irritant vapours.

All this may sound very obvious but the problem is not so simple as it seems and I will end with a mere hint at the pitfalls which lie in the path of the unwary. So far we have reckoned without the human factor. To be laid off work by an industrial dermatitis is a major catastrophe, economically if in no other sense. Moreover, the evil reputation attached to the condition does nothing to lessen the anxiety engendered in the unfortunate victim. The doubt whether he will ever be able to return to his former occupation and the prospect of less remunerative employment weigh heavily, and even the prospect of compensation does not altogether relieve his anxious mind. As healing takes place it is accompanied by a fear for the future and a growing reluctance to put the skin to the test. The victim loses his confidence in his skin and the time comes when his one-time antigen-antibody reaction is replaced by an anxiety neurosis, with its associated eczematous manifestations. With a mind growing even more tense, the patient itches and broods, broods and scratches, and his eczema flourishes. *Mens sana in corpore sano* by all means—but how true is the converse.

Thank You, Readers

MADAM.—The members of the Edinburgh Branch of the Royal College of Nursing have asked me to convey to you their thanks and appreciation for the way in which you have succeeded in keeping the *Nursing Times* going during the recent printing dispute. They realize how much effort it must have meant for you and they are extremely grateful.

MARION MACDONALD, Hon. Secretary.

* * *

MADAM.—We have noted with dismay the difficulty you are having with your printing. This is just a brief note to tell you that you have our sincere sympathy in your predicament. We will be relieved when we hear that the labor dispute that is causing interruption in your production has been settled.

NELL V. BEEBY, R.N., Editor,
The American Journal of Nursing.

TRAINING PSYCHIATRIC NURSES

A CHANGE OF EMPHASIS

by M. M. Glatt, M.D., D.P.M., Assistant Psychiatrist; B. M. Mandlebrote, B.SC., M.B., M.R.C.P., D.P.M., Assistant Psychiatrist; K. F. Weeks, M.B., D.P.M., Senior Registrar; K. Brennan, S.R.N., R.M.N., S.C.M., Matron, and S. Moore, S.R.N., R.M.N., S.T.D.(LOND.), Chief Male Nurse, Warlingham Park Hospital, Surrey.

THE change of emphasis in mental hospitals from custodial and physical care to more active treatment and rehabilitation has altered the role of the psychiatric nurse. A survey of patients and their psychiatric management in a 1,065-bed psychiatric hospital serving the county borough of Croydon (population 250,000) shows that the mental hospital should not be regarded either as a type of prison or as a special addition to a general hospital.

In this particular hospital over the past 20 years the experiment of reducing restrictions by gradually unlocking the doors, allowing the mixing of the sexes, and encouraging the patients through the activities of the nursing and medical staff to play an integral part in the community life of the hospital, has resulted in a considerable reduction of the problems of the hospital. It is apparent that the vast majority of patients in a mental hospital can be essentially harmless well-behaved patients. Only one per cent. of patients in this hospital are considered from time to time as potentially dangerous. On the male side of the hospital there were only three instances of minor physical assaults on the staff over the past year, assaults among patients having been reduced to 54 over the year, while there were only seven instances of smashing of windows and damage to hospital property.

As a striking comparison to the general hospital the vast majority of patients are neither physically ill nor feeble; most of them are in fact physically healthy and ambulant. Only 39 (less than 4 per cent.) of the 1,065 patients of this hospital are physically ill, infirm or non-ambulant. Thus the training problem for a psychiatric nurse is very different from the training of nurses for general hospitals since the bulk of their work is directed towards the management of ambulant, physically healthy patients, and the nurse is chiefly concerned with their interpersonal relationships, rehabilitation, and resocialization.

Influence of the Nurses

The influence that the nurses exert over the patients should not be underestimated. For it is the nurse who first sees the patient when he enters hospital, from her he gets his first impression of the attitude of the hospital in general towards patients in general and towards himself in particular. Furthermore, however important the special physical or psychological treatments are, they occupy only a very small proportion of his time and events during the rest of the day may undo much of the good done by the treatment. The nurse has the opportunity of being closest to the patient, being responsible for him 24 hours in the day, seven days in the week. Whatever the nurse does or does not do, her relationship, attitude and behaviour to the patient is therefore of the greatest importance for him.

An article based on a memorandum submitted to the World Health Organization Expert Committee on Psychiatric Nursing and accepted as Working Document No. 4.

The psychiatric nurse needs to be a specialist in social relationships, expert in handling the individual as well as groups, in encouraging and directing his activities, stimulating his initiative, developing his responsibility and increasing his self-esteem.

One hundred years ago all jobs in a mental hospital relating to the occupation of the patients were carried out by mental nurses. Over the past 20 years more emphasis has been placed on the active treatment of patients in mental hospitals, on the need for occupational therapy and the study of social and family problems. This has resulted in the birth of a new group of specialists in the shape of the psychiatric social workers and occupational therapists in the mental hospitals, taking away from the psychiatric nurse important activities which had formerly been in her province and introducing specialized workers outside the rank of psychiatric nurses for the more important and attractive jobs. This leaves the nurse with a feeling that she has only a minor function to fulfil in comparison with these other workers who have better status.

Well-planned Activity

Activity now is the keynote of the modern hospital; as far as possible all patients should be employed in some form or other of well-directed and planned occupational activity. To leave this work exclusively to a few occupational therapists will give the psychiatric nurse the feeling that occupational therapy is not part of her job, and in fact the great majority of hospital patients would not be employed at all.

The nurse must be encouraged, and trained, to stimulate, plan and direct her patient's activity and thus to regard herself also as an occupational therapist. Again, as far as social work is concerned, by becoming an expert in human relationships and by intimately knowing the individual patient under her care, his abilities, his emotional difficulties, his defects and his assets, she could, with some additional training, be the best intermediary between the patient, his family, his future employer and the world in general. The knowledge that it would be possible for her to advance to more specialized work, and not to be a mere attendant and second-rate ' looked-down upon ' type of general nurse, will encourage the entry into the profession of an intelligent type of person, who will feel that there is emotional satisfaction in the work she does, that she is doing a responsible and specialized type of job and that she has the status and recognition this work deserves.

The fact that all the occupational therapy in the male and female parts of this hospital and a considerable part of the social therapy both inside and outside the hospital are carried out by psychiatric nurses with success, is a pointer for the provision of further opportunities for psychiatric nurses in these fields.

At present training concentrates on the physical aspects of nursing and the curriculum begins with the

same general education in the sciences relevant to nursing as that in the general nursing curriculum. It would be preferable to consider ways of training the psychiatric nurse more specifically for the type of work which she will be required to carry out from day to day with psychiatric patients in mental hospitals.

Specific Training

The nurse in the mental hospital meets a widely diverse population and her handling of very deteriorated patients in need of habit training must, of course, be quite different from that required in looking after disturbed patients. Early psychotics and neurotic patients and psychopathic patients all require handling in different ways. From the beginning a nurse should be encouraged to think of herself as a member of a therapeutic team; should learn to acquire understanding, sympathy, tact and tolerance in dealing with her patients instead of relying on strict discipline and authority. Attending actual discussion groups for special groups of patients, or ward discussion groups, will help her greatly in this connection. The nurse will also require some training in the organization of recreational activities, in participation in social clubs, and in the role she is to play in extramural activities held in the community itself, as in time these will play an ever-increasing role in the organization of the community mental health service.

The importance of these roles is self-evident when one analyses the time spent at this hospital. It is very interesting to note that on the male side where the nursing shortage is not so acute, only 10 per cent. of nursing time is spent in wards for the physically ill and infirm (and of this time only 5 per cent. is spent in actual physical nursing); another 5 per cent. of the nursing time is spent in assisting at physical treatments (E.C.T., insulin, leucotomy, etc.), while of the remaining time 10 per cent. is spent in the habit training wards, 15 per cent. in recreational activities and 30 per cent. in occupational groups, non-productive activity groups, discussion groups and dealing with social and family problems. On the female side, with the greater relative shortage of nursing staff, 20 per cent. of nursing time is spent in wards nursing the physically sick (of which only a small proportion is devoted to physical nursing), and nurses are not sufficiently available to participate in discussion groups and non-productive activity groups which would flourish more satisfactorily if they were available.

It is no more necessary that psychiatric nurses be able to deal with *all* physical illness than it is that general nurses should be able to deal with *all* mental disturbances in general hospitals.

[We would like to express our thanks to Dr. T. P. Rees for his encouragement and advice.]

Book Reviews

Introductory Foods

(third edition).—*by Osee Hughes.* (*The Macmillan Company of New York, London Branch, 10, South Audley Street, London, W.1, 33s.*)

This book is written by an associate professor of Ohio State University primarily for teachers of nutrition. The book covers a wide field of study, and it is written in a comprehensive manner which recommends it to tutors of nursing schools as a basis for the teaching of nutrition.

The introduction gives the relation of food to health and describes why good nutrition should continue throughout a large part of the life cycle. The vitamins are classified and their functions clearly defined. A point of interest to nurses is the reason given for using dark glass bottles for the storage of the fat-soluble vitamins; exposure to light develops rancidity which destroys the vitamins.

An important subject to many engaged in the feeding of patients is the palatability of foods. The author has given some helpful hints on the contributory factors in varying the degree of flavours to suit the individual. The digestibility of food is carefully explained; it is interesting to read that a lightly cooked egg is more completely digested than a raw one. I am sure the discussion upon the preservation of food will be read with a feeling of thankfulness to the author, who states: "It has been definitely proved that canned foods may remain in the tin after opening without any danger to health, also there is no proof that aluminium cooking pans impart harmful qualities to food. Galvanized utensils are unsuitable for food as the zinc used for galvanizing is toxic."

The book includes chapters upon the composition and nutritive value of all foods in common use, together with special methods employed in the processing and freezing techniques so popular in modern food preservation. A chapter is devoted to milk, its composition, physical properties and methods of processing and sterilization; although the methods described are those used in the United States, similar methods are employed in this country by all the large milk distributors.

The author has included some excellent information, accompanied by illustrations about eggs, egg cookery and egg preservation at home. All nurses concerned with diets for patients will be much enlightened upon this article of diet. The buying and cooking of meat, fish and poultry is described with animation and is also beautifully illustrated.

Beverages occupy an important place in the diet; it is therefore very gratifying to be able to read a chapter upon the growing and preparation of coffee, tea and cocoa, and a variety of methods are also given in the making of these beverages. The book includes some very delectable recipes for ice cream and desserts, together with biscuit and cake recipes, illustrated to show good results and failures in the baking.

The concluding chapters contain useful information upon meal planning and serving for the family, also procedures for canning fruits, vegetables and meats. Although the book is an American publication, the general text is easy to follow and translate into terms as used in this country. I found the book a fund of practical information and recommend it to be read by students of domestic science and students of nutrition who may be engaged in the planning and preparation of menus for patients.

F. D., S.R.N., S.C.M., Diploma in Dietetics.

The Mentally Retarded Child

A Guide for Parents.—*by Abraham Levinson, M.D., edited with a preface to the British edition by Kay McDougall, Psychiatric Social Worker.* (*George Allen and Unwin Limited, 40, Museum Street, London, W.C.1, 12s. 6d.*)

Dr. Levinson sets out to help parents who for the first time are facing the problems presented by a mentally retarded child. The first difficulty these parents have to meet is the fact that one or perhaps their only child will never be able to do things which the normal child can do. The acceptance of a handicapped child involves an

enormous emotional strain on these parents, and means a reorganization of their attitude towards the child and his handicap.

One feels that to Dr. Levinson each child is an individual to be understood and helped to take his place and make his contribution, however small, to the community. He shows how necessary it is to investigate every aspect of the child's development, medical, psychological, intellectual, social and emotional; the assessment of the child's potential ability is essential before the parents can be advised on his future care and guidance. Dr. Levinson shows how necessary it is to support and encourage parents to face and understand their problem if they are ultimately to be in a position to help and encourage the child.

When parents and teachers know and understand the child's limitations they are able to work together to extract the utmost response from the child. The parents are helped by Dr. Levinson to face the problem of institutional as against home care for such a child, and he wisely points out that each child and his family must be considered as an individual unit. Advice must only be given when all the facts have been taken into consideration. Dr. Levinson rightly says that provided normal children in the family do not suffer because of the parents' too great concentration on the handicapped child, he should remain in the family, receiving loving care, support and encouragement.

Throughout the book emphasis is laid on the futility of allowing parents to trail from one doctor or hospital to another. Early consultation and diagnosis will help to relieve the parents' anxiety and help them to accept the child's limitations. The acceptance of these children by the State for educational and vocational training is clearly set out.

Dr. Levinson emphasizes the need for research into the causes leading to mental backwardness and hopes that many of the causes may be removed.

Social workers, health visitors, houseparents and foster parents caring for mentally handicapped children will welcome this book.

M. S., S.R.N., S.C.M., H.V.CERT.

Housewife Baby Book

(second edition).—*by Anne Cuthbert.* (*Hulton Press Limited, 43-44, Shoe Lane, London, E.C.4, 5s.*)

This is a neat little book, with a shiny paper cover that looks so nice until the back comes unstuck. This is a pity, because it is a book to refer to over a long period, and I doubt if it will stand up to the wear it deserves. But you get a lot for your money, and I suppose you would have had to pay more still for a better binding.

The author has had wide experience both as a mother and as a health visitor, etc. I feel it may even be her experience as a grandmother that prompted the introduction to the second edition with its note of warning against the experts. Very often the mother really does know best, if her confidence has not been sapped by too much advice. " We have earnest young women searching the books . . . for help, while screaming infants implore them in vain to do what Nature dictates and take them into their arms."

However, some facts are facts, and should be known, and the ideas and conclusions of those who have been this way before are interesting and helpful. Mrs. Cuthbert has tried to keep facts and opinions separate, and says " Each chapter opens with a general survey of the subject and ends with tabulated facts ".

The chapters range from 1. ' Expecting a Baby ', to 13. ' Schooldays and After '. There is also an appendix containing information about the Rhesus factor, some useful addresses and book titles. And there is an index.

Naturally there are small points which one could pick on—for example, what does ' nutritive ' mean? How can one say that mineral salts and even vitamins are not nutritive as they do not satisfy hunger? We would be very malnourished without them. And there is a short and sensible paragraph on reading and writing which includes the statement that the average child will best learn to read at the beginning of the sixth year. I have a theory that this assumption is the root of the trouble with modern education. My generation was taught to read by mother, before we started on school and its distractions; I think I was about four-and-a-half. At this age the child is inquisitive, eager to learn and able to memorize, and bored with play. If you miss this moment, he will not again be ready to concentrate until he is seven or eight, by which time his teachers will have wasted a lot of hard work on him. This, of course, is beside the point in a review of a baby book!

D. R. C., M.B., B.S.

A Pharmacopoeia for Chiropodists

(sixth edition).—*by J. N. Le Rossignol, F.Ch.S., and C. B. Holliday, M.P.S.* (*Faber and Faber, Limited, 24, Russell Square, London, W.C.2, 15s.*)

The authors have set out to provide technical information on a number of substances used in the practice of chiropody, but it is inaccurate to call the book a pharmacopoeia—at any rate in the modern sense of that term, since it sets no standards for the materials to which it refers. It may, nevertheless, be a useful textbook for chiropodists.

The main difficulty the authors have had appears to have been that of selection of material for inclusion. In fact too many preparations are dealt with. Much of the information is not relevant to the needs of chiropodists: for example, it is doubtful whether it is either interesting or helpful to them to know that menthol is obtained from mentha arvensis, var. piperascens or var. glabrata or from mentha piperita, etc. Most of the pharmaceutical information suffers from this defect of overloading. The use of Latin titles for preparations of the British Pharmaceutical Codex is incorrect. The titles in the 1954 edition of that book are all in English. It is only confusing to the non-pharmaceutical user to revert to the older nomenclature.

The paragraphs on actions and uses are uncritical. A smaller book with drugs classified according to their principal use would have been more practical.

H. S. G., PH.C., F.P.S.

The Lure of Surgery

—*by George Sava.* (*Faber and Faber Limited, 24, Russell Square, London W.C.2, 15s.*)

Admirers of Mr. George Sava's popular writings will not be disappointed in this his latest book. They will know from his previous works that his greatest ambition from his earliest days was to become a famous surgeon. Here he relates with thinly veiled bitterness his failure to get an appointment on the staff of an English teaching hospital and his success as a surgeon and lecturer in America. *The Lure of Surgery* describes his work there and his success as a plastic surgeon. Instructive detail of medical interest is almost entirely lacking, but of drama, sentimentality and self-satisfaction there is a surfeit. Nevertheless, the book is readable and interesting in its own way, and will no doubt be a best seller. It cannot be ranked as a serious addition to medical or nursing literature.

H. M. G., D.N.(LOND.)

A Post-operative Observation Ward

by Elizabeth M. Skellern, S.R.N., Southend General Hospital.

TO establish a post-operative observation ward in a busy general hospital such as we have at Southend has presented many difficulties. Our main problem has been lack of space. The hospital is not designed to accommodate a recovery ward, so as a temporary measure we have converted a two-bed ward which is within immediate reach of the two main theatres. This allows us to take only a few selected cases at present.

This idea has caused some controversy among the ward sisters, who feel that their acute surgical nursing is taken away and that the nurses in training are not getting experience in the nursing care of the unconscious patients. It is hoped that these points will be remedied when the scheme is run on a larger scale, when all post-operative patients will return to the recovery ward for observation. This will necessitate having nurses in training who will be given more detailed instruction in post-operative nursing care and who will have the opportunity of following these cases through the theatre with the anaesthetist.

Equipment

We have received every co-operation in the provision of equipment for this new scheme. For instance, we are adequately supplied with electric suction, oxygen, instruments and sterilizing facilities, and have our own supply of drugs.

A sliding door has been installed, allowing easier transport and giving more room for beds and trolleys going to and from the theatre. We have our own portable drip stands and bed elevators, and any other such equipment necessary is obtained directly from the wards. The ward is supplied with an anglepoise lamp as well as overhead lights, and lights over each bed. The two beds are separated by curtains. There is one washbasin for the two beds. All this makes us practically self-contained. When the ward is extended more equipment will of course be necessary.

General Layout of Trays

The following trays are always kept in readiness:

(1) **Post-anaesthetic Tray.** This includes:

(*a*) sponge holding forceps	(*f*) airways
(*b*) tongue clips	(*g*) endo-tracheal tubes
(*c*) wooden wedge	(*h*) laryngoscope
(*d*) mouth gags	(*i*) Nupercaine ointment
(*e*) rubber catheter for electric suction	(*j*) guttae liq. paraffin
2 dressing bowls	vomit bowl
receivers	gauze and wool swabs
gallipots	dressing mackintosh
sputum mug	anaesthetic cloth

(2) **Stimulant Tray.** This sterile tray is kept in readiness for giving hypodermic intramuscular or intravenous injections as required. The tray contains:

receivers	Ampoules of
dissecting forceps	adrenalin
gallipots	Methedrine
syringes } dry, sterilized	nikethamide
needles } and in spirit	atropine
gauze and wool swabs	distilled water
tourniquet	sterile normal saline

Other Trays.

aspiration tray	mouth tray
back tray	

A trolley is always kept in readiness for any sterile procedures. Intravenous cut-down transfusion sets and tracheotomy sets are available direct from the theatre.

How the Ward is Run

At present the recovery room is run by a full-time and part-time staff nurse, with myself as sister during the day, and a third-year student nurse at night, allowing us to run a full 24-hour service.

We work directly under the anaesthetist and surgeons and report to them each morning to decide which cases are most likely to need special care. We try, as far as possible, to visit these patients in their wards before they go to the theatre, explaining to them that they will be nursed in the recovery room, so that they can receive constant attention during the immediate post-operative period. We find that this helps to allay any feelings of apprehension, and any fears they may have before the operation are discussed with them.

The patients' beds are sent to the theatre, and after operation the patients are collected by us and brought directly to the observation ward. The nurse is instructed regarding any special post-operative treatment by the surgeon or anaesthetist in charge of the case. Any immediate change is reported directly to the anaesthetist or surgeon. We have been trained by the anaesthetist to recognize any emergencies which may arise.

We have already noticed many interesting features since we have 'specialled' these cases, noting for instance the effect of certain post-operative drugs which can produce rapid hypotension.

The effects of extra-dural blocks may cause severe shivering attacks, and hypotension following these anaesthetics is watched carefully and necessary measures taken to counteract side-effects.

In some cases patients having come round from the anaesthetic will lapse into unconsciousness following sedation, necessitating the replacement of an airway.

The surgeon decides when the patient is fit enough to return to the ward, and they are transferred with full written reports to the sisters-in-charge. The patients may require special attention up to two to three days.

Ideally, the patients benefit in the majority of cases, by being kept quiet up to 12 hours following operation.

Advantages and Disadvantages

It has been found from the experience of other hospitals that the initial outlay of an observation ward is expensive, but economical in the long run. In the short time we have had the recovery ward the following advantages have become evident.

(1) The equipment is centralized.

(2) The nursing staff is used economically and more

(*continued on page 245*)

From a lecture given at a study day at Southend.

If you are a trained nurse, dedicate your service to the soldiers of the Queen. In return you will know adventure, travel, and the prestige of a commission. There is unlimited scope in Q.A.R.A.N.C. for advancement in many spheres in the profession, as well as to higher rank in the corps itself. Your service may take you to Singapore, Malaya, Hong Kong, Japan, Africa, Gibraltar, Bermuda, Malta, Jamaica, Germany, or on troopships. Write to the address below for illustrated leaflet giving full details of the opportunities that await you.

MATRON-IN-CHIEF,
WAR OFFICE
(AMD4/TN/15)
LONDON, S.W.1.

...in every corner of the world...

in QARANC

QUEEN ALEXANDRA'S ROYAL ARMY NURSING CORPS

Welcome in every Nursery . . .

These KAMELLA NESTLING RUGS in soft cosy PURE WOOL are essentials in every Nursery—as a shawl, pram rug, playpen rug or extra cot cover. In a very attractive range of plain shades or decorated with animal motifs and hand embroidery; also a variety of check and overcheck designs.

Also KAMELLA BLANKETS in Pure Wool cellular fabric, with satin bound or plain ends. All FULLY GUARANTEED—replaced if proved faulty in washing or wearing.

Prices (approx.): Nestling Rugs (30 in. × 36 in.) from about 22/-. Blankets (35 in. × 40 in.) from about 20/-; (40 in. × 60 in.) from about 30/-.

It pays in the end to buy Kamella in the beginning.

Also the original Baby Bag, Bag/Dressing Gown Dressing Gowns, Pram Coats, Pram Rugs, T-Shirts, and Shorts, Beachwear, Underwear, etc. At all leading Stores and Baby Shops. Write for free booklet: KAMELLA LTD., Bolton Road, Bradford.

Kamella

NESTLING RUGS & BLANKETS

Two of the Kamella GUARANTEED Health Range...

A really up-to-date general purpose skin balm

RESEARCH has produced a really up-to-date general purpose skin balm. You can recommend it with confidence to your patients because it incorporates two scientific advantages :—

1. Valderma antiseptic balm, as it is called, contains *two* antiseptics. One of these is the water-soluble Pot. Hydroxyquinolin. Sulph. (0.2%). The other is Para-chlor-meta-cresol (0.2%) an antiseptic which is soluble in the oil phase of Valderma's special emulsion base. The incorporation of both these antiseptics accounts for Valderma's effectiveness against an extremely wide range of bacteria. It is particularly useful against Staph. aureus, Staph. albus, Strep. viridans, B. coli and B. megatherium, as tests by the "Agar-Plate" method have shown.

2. Valderma has an "oil-in-water" emulsion base. This means it washes off easily; does not stain linen and, unlike fatty ointment bases, allows septic discharge to escape. It is creamy, white, non-greasy.

Valderma has given remarkable results in pyogenic infections of the skin. It swiftly soothes irritation, helps heal many common skin troubles. Valderma is absolutely safe for babies — nappy rash, 'heat' spots, etc.

SCIENTIFIC EVIDENCE

A booklet entitled "A Notable Contribution to Dermal Therapy", containing illustrations of a series of bacteriological tests made at a British University, and particulars of clinical tests made at a British hospital, will be sent free on receipt of a postcard to Valderma Laboratories, 15, Berners St., London, W.1.

(continued from page 243)

efficiently, being specially trained in the care of the unconscious patient, which results in safer post-operative care.

(3) Psychologically, patients are reassured, and other patients in the ward are spared the depressing sight of a patient coming round from an anaesthetic.

(4) Patients can be given more individual attention and treatment. The wards are therefore relieved of the acutely ill patients.

With the introduction of controlled hypotension, the recovery ward has become, in our minds, essential. Changes of posture after operation have to be so carefully controlled that we have felt that transport to a ward at a distance from the operating theatre and the anaesthetist would be a deterrent to the use of this procedure, so necessary in modern surgery.

Disadvantages of this system are: (1) Lack of space. (2) When the recovery room is run on a larger scale, difficulties may arise in dealing with several doctors and consultants.

Despite the many difficulties to be overcome, the establishment of such a recovery room is becoming increasingly popular in modern hospitals, and we hope in future to have sufficient beds to give all surgical patients the benefit of specialized treatment during the immediate post-operative period.

Selection of patients before their operation may well be uncertain—it is not always possible to determine which patient is going to give trouble. It is urged that all these patients pass through a recovery ward—thus there can be no regrets or recriminations for incorrect selection.

[I would like to thank Miss Parker, matron, for permission to publish this article.]

Four Months in a District Hospital

by GEORGE O. SCORER

IN my younger days I used to pray that when my time was up I might pass on with a body intact and with a mind at peace. But recently, at the age of 82, I was suddenly rushed off in an ambulance for an emergency operation, and for the first time in my life I found myself in the surgical ward of a hospital—with a body no longer intact, but still banking on that final peace of mind.

While still rather dazed I noticed what appeared to be an endless stream of sisters and nurses passing my window on their way to and from their nearby hostel, and I started to wonder how a sufficient supply of patients could be obtained to meet the demand for cases needed for the training of such a vast staff. However, I need not have worried, as I soon realized that it was not patients but nurses who were in short supply.

An early contact at this stage was my anaesthetist, whose laconic "Hello! I didn't expect to see *you* again!" suggested that my condition when in his care must have been precarious.

As an architect I had many opportunities of studying hospitals, both in London, where I was a life governor of St. Mary's Hospital, and in Vienna, where I was commissioned to report on a great hospital which at that time was the most modern in existence, as well as on the numerous guild and private nursing homes.

But my research concerned their planning, structure, and equipment rather than their actual running, and now I was to have a new experience of routine work, and of the human side comprising staff and patients.

My first impression was of wonder how it had been possible for the nurses to cope with my bodily functions and needs during the time when I had been unconscious, and of thankfulness at having been kept entirely free, from first to last, of anything like pain.

My original idea that patients spent long hours of undisturbed peace, or possibly of boredom, was soon dispelled, for there were few intervals during the day when there were no activities in progress.

With time on my hands, and with an unwonted disinclination to read, I interested myself by studying the duties and personalities of the nursing staff, and I soon decided that pride of place must be given to the ward sister, for so much depended upon her.

Next in importance on my list I placed the staff nurses, one of whom was always on duty in the ward during the day. Then came the various grades of nurses, some highly experienced and due for a rise in status, and younger ones with shorter training but doing their job conscientiously and bravely. To this list must be added the male nurses, whose services were much in demand, and to whom I owe a debt of gratitude for their help in many awkward predicaments.

Every week the senior surgeons made their rounds of the ward, usually on a Monday—the day, according to a ward maid, when they selected their victims for the week! New patients were prone to anticipate these inspections with some anxiety, but they soon realized that they were made in order to ensure that everything was done for their comfort and recovery.

Patients, including the small boys of whom there were usually two or more, soon accepted as purely routine happenings the frequent arrival of the porters with their wheeled stretchers or chairs for the conveyance of patients to the operating theatre or X-ray department.

The patients in the ward with me, usually numbering about 24, came from all walks of life. There were professional men, business men, clerks, tradesmen, farmers, gardeners, etc., and it was intensely interesting to watch how they reacted, almost without exception, to their new experience. A first aloofness quickly gave way to friendliness with, and consideration for, their fellow sufferers, as well as for the staff. In fact, life in the ward had an extraordinary humanizing influence on all concerned, patients forgetting their own troubles by interesting themselves in the welfare of others. For example there was the solicitude of an outgoing patient who begged me to keep an eye on an old sergeant-major who, as we both knew, was very lonely.

During my four months in the ward I made many notes about individual patients. For instance, there was the big virile old man of 90, who was the father of 20 children, the oldest of whom was a daughter aged 70; when asked about all this he used to say "No, it was not I who had the children, it was my wife."

Often at night one was woken up by the arrival of a casualty—chiefly at weekends when road traffic was heavy—and this would be followed by the arrival of anxious relatives, and sometimes by police officers anxious to get a statement.

Such cases received prompt attention from the staff, X-ray apparatus being brought in and blood transfusions being given when necessary. Here I must pay a tribute to the kindly thought of nurses who often surreptitiously provided a very welcome cup of tea for patients disturbed from their rest by such comings and goings.

To most of us the great event of the day was the arrival of friends at visiting time; I was very fortunate for I never lacked a visitor, whereas there were a few lonely souls who seldom had one. Few of us realized that the weather our visitors had to face was often bitterly cold and wet, and so unlike the constant warmth of the hospital. The plaintive remark of a patient "I never realized till now how three-quarters of an hour could seem to pass in 10 minutes" voiced what we all felt when the bell rang for visitors to leave.

During my four months' residence I found, as an architect, certain drawbacks, but these were chiefly due to the conversion of the building from its original emergency type to that of a more permanent status.

In an age when noise is often accepted as inevitable it should be reduced to the minimum in a hospital, and I found little excuse for doors constantly being allowed to bang, nor for the clatter of crockery in the nearby service room. There was also, too, much unchecked chatter in the ward, some of the worst offenders being patients who ignored the need of their fellows for peace and quiet.

As an architect again, I noted these faults: the lighting of the ward at night would have been better effected by concealed strip-lighting, for it was quite impossible to avoid the glare from the ceiling lights even when dimmed, except by burying one's face in a pillow; the ventilation of the ward would have been vastly improved by fresh air inlets behind the radiators, at floor level, and of outlet vents at ceiling level for the removal of stale air.

Lastly, I would suggest that some provision be made for the washing of patients' personal effects, as at present soiled pyjamas, handkerchiefs, etc., have to be stowed away in the bedside locker until some visitor takes them away to be dealt with.

In conclusion, I must pay my tribute to the quality of the food, for it was excellent, including that prescribed for patients needing special diets.